1475 Taney Avenue, Ste 201
Frederick, MD 21702
Medical Records (301) 631-8055
Main (301) 662-0133 Fax (301) 695-8604

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I. Patient's Name _____ DOB _____Phone Number _____

II. Please check one and provide the requested information:

☐ I hereby authorize The Pediatric Center of Frederick, LLC and any of its Medical Providers to disclose my Protected Health Information to the following organization(s) and/or person(s):

Name _____

Address_____

Phone Number: _____Fax Number: _____

☐ I hereby authorize _____to disclose my Protected
(Primary Care Physician or other Health Care Provider)
Health Information to The Pediatric Center of Frederick, LLC and any Pediatric Center health care provider.

III. I authorize the following information to be disclosed:

Please check one and provide the requested information:

☐ _____ Complete Medical Record, including records from other providers and immunizations
☐ _____ Complete Medical Record, not including records from other providers
☐ _____ GYN (Pap, Pelvic, Lab)
☐ _____ Lab
☐ _____ X-ray
☐ _____ Other or Relating to Particular Problem_____

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information.

☐ At the request of the patient. _____
(Patient's initials)
☐ Other _____
(State specific purpose of requested disclosure)

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to The Pediatric Center of Frederick, LLC or other health care provider identified in Section II above, as applicable. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that The Pediatric Center of Frederick, LLC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize The Pediatric Center of Frederick, LLC to fax the information, I realize there are inherent risks in faxing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

This authorization expires upon_____

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____